Reimbursement Offer for Weight Watchers® Offerings *(Revised 12/02/08)*

Important Notice: Only individuals who are currently participating in an eligible Weight Watchers® program or who sign up prior to December 31st will still be eligible to receive a full reimbursement at the completion of their program if all reimbursement criteria are met.

State of Delaware Group Health Insurance Program Participants
(Eligibility is for employees, pre-65 retirees, spouses and dependents who are 18 years of age or older)

To receive your Weight Watchers® reimbursement:

1. Check the applicable Weight Watchers® offering for which you are requesting a reimbursement:

Weight Watchers® Meetings:

[ ] At Work Meeting [ ] Local Meeting Voucher [ ] Monthly Pass

To be reimbursed, you must complete a minimum of 10 weeks of your offering **AND *attend*** the number of weekly meetings – not just weigh in and leave - as defined below prior to submitting. Please check the applicable service item below :

[ ] Local Meeting Voucher/At Work - I attended 10 out of 13 meetings

[ ] Local Meeting Voucher/At Work - I attended 15 out of 18 meetings

[ ] Monthly Pass - I attended 10 meetings in a consecutive 3-month period - You must send in your Account Status Page for proof of payment. To get Account Status, visit My Profile at www.weightwatchers.com

Weight Watchers® Online / At Home Kits:

[ ] Online Subscription [ ] At Home Kit

To be reimbursed, you must complete a minimum of 10 weeks of your offering. If your form is received prior to completion of 10 weeks, your reimbursement will not be honored. Please check the offering below for which you are seeking reimbursement:

[ ] Online – you must send in Account Status Page. To get Account Status, visit My Profile at www.weightwatchers.com

[ ] At Home Kit – send in proof of payment (i.e. receipt, cancelled check, copy of online bank statement, charge card statement, etc) along with proof of date ordered

2. Enter the total amount paid for the Weight Watchers® offering purchased that you are seeking reimbursement: $_____.
(Monthly Pass members should enter the amount paid in the 3-month period they are seeking reimbursement)

3. Have your Weight Watchers® Leader or Receptionist complete the below certification:

I certify that _____has purchased a ___ week series at a price of $_____ **AND** attended the required amount of meetings for the offering purchased.

_____ _____ _____
Weight Watchers® Leader/Recept. Signature Meeting Name or Location # Date

4. Provide the dates of the meetings that you attended: _____

5. Mail this completed form, along with proof of payment, to the health care plan address which you participate:

Blue Cross Blue Shield of Delaware (BCBSD)
SOD Weight Watchers® Reimbursement
PO Box 8830
Wilmington, DE 19899-8830

Aetna
SOD Weight Watchers® Reimbursement
655 S. Bay Road, Suite 1A
Dover, DE 19901

Questions regarding the status of your reimbursement should be directed to your health care insurance program (BCBSD or Aetna).

BCBSD (800) 633-2563 **Aetna (877) 542-3862**

By providing the information below and submitting this reimbursement form, you acknowledge and agree to the following Terms and Conditions: *This form must be fully completed and include all documentation for reimbursement (dependent upon the Weight Watchers® offering identified above) and sent to BCBSD or Aetna **within 30 days of the last day of your offering** or the last day of the month for Monthly Pass participants. Keep copies of all material submitted. Blue Cross Blue Shield of Delaware and Aetna are not responsible for lost, late or misdirected mail. Reimbursement checks are ordinarily processed within 30 days of receipt. Void where prohibited or restricted by law. Availability and terms of reimbursement may change without notice.*

Employee to complete[1]:

Weight Watchers® Participant Name: _____

Employee/Retiree Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Phone: _____

Employer/Company: **State of Delaware Group Health Insurance Program** Health Insurance ID #: _____

[1] The information submitted on this form will not be used for any purpose other than for the processing of this reimbursement.